Denver Public Schools

Division of Student Services

Resource Team Referral

*To be completed electronically by the school and submitted via email to the Student Services OSII for that region.*

**Signature of Principal or A.P.**  **Date**: Click here to enter a date.

**Student Information:**

**Name:**       **Date of Birth:**Click here to enter a date. **Grade:**

**School:**       **Student ID #:**

**General Education Teacher:**

**Special Education Service Provider/Case Manager:**

**School Contact and Title:**  **Phone:**

**Parent/Guardian:**       **Parent Phone:**

**Parent/Student** **Address:**

**Parent Contact:**

**Date:** Click here to enter a date. **By whom:**

**Parent Response to referral:**

**Support Requested:**

ATRT Specialist Autism Specialist Behavior Specialist Twice Exceptional Specialist

Individual Student Classroom Referral

**Complete the following information**

1. Describe the student’s/classroom current educational programming and services.

1. What is the presenting problem?

1. What do you want the student/class to be able to do that he/she is not able to do now?

1. What are the student’s/classroom’s strengths?

1. What strategies, interventions, and/or technology have been tried in this area? What were the results?

1. What are motivators for this student/classroom?